For Office Use Only

Responsible Party _____

Child's Name _____

PDD PROGRAM LINE THERAPIST RESPONSIBILITIES AGREEMENT

As a Line Therapist, I understand that:

1. I must have annual PPD Tuberculin skin tests unless I have a documented history of a positive PPD. In that case, I will complete a questionnaire for signs and symptoms of TB annually and submit it to my employer, the Responsible Party.

2. Line Therapist services include:

- Implementing interventions designed in the EIBI plan
- Recording data
- Reporting progress and concerns to the Lead Therapist
- Completing and submitting the **PDD Program Responsible Party Line Therapist Daily Log** as required
- Attending all required training sessions
- Adhering to assigned work schedule

3. I am responsible for maintaining individual consumer records. These records are subject to HIPAA and the confidentiality rules for all Medicaid Providers and shall be made available to the Autism Division and Jasper County DSN Board upon request. Records shall include the following:

- Consumer charts and graphs
- Consumer data sheets
- Daily logs

4. It is my responsibility to notify the Service Coordinator of the following:

- A change in the child's condition (e.g. displays of challenging behaviors not previously shown)
- My wish to terminate as the provider of Line Therapy services
- The responsible party's desire to no longer serve in that role
- My inability to provide Line Therapy services as authorized--**THIS MUST BE DONE IMMEDIATELY BY TELEPHONE**.

5. I am responsible for:

- Completing the daily log prior to obtaining the responsible party's signature
- Maintaining copies of the completed and signed daily log for Medicaid and tax audit purposes
- Sending copies of the completed and signed daily logs to the Service Coordinator for review on a monthly basis

6. I am responsible for signing and completing all paperwork required by the Jasper County Board of Disabilities and Special Needs (DSN) Board in Ridgeland, South Carolina. The Jasper County

Board of Disabilities and Special Needs will be the mandatory fiscal agent for the parents/legal guardians who choose Responsible Party Directed services.

7. All hours worked should be totaled and comments written **prior** to obtaining the Responsible Party's signature on the **PDD Program Responsible Party Line Therapy Daily Log**. I am responsible for:

- Maintaining copies of the completed and signed daily logs for Medicaid and tax audit purposes
- Sending copies of the completed and signed daily logs to the Service Coordinator for review on a monthly basis
- Submitting the daily logs to the Jasper County Board of Disabilities and Special Needs as specified; they will be responsible for issuing my checks and taking out my taxes.

8. The **PDD Program Responsible Party Line Therapy Daily Log(s)** will be used for reimbursement purposes. The **PDD Program Responsible Party Line Therapy Daily Log(s)** cannot be filed and reimbursement will not be paid until the Service Coordinator authorizes the service and I have provided the service.

9. I understand that the Responsible Party will not sign the **PDD Program Responsible Party Line Therapy Daily Log** if it is not accurate and, that I may be terminated if I misrepresent the hours I worked.

10. I understand that no services may be provided while the child is in a school setting.

11. I understand that I will be unable to serve the child if I am or become the child's legal guardian.

12. I understand the Responsible Party is my employer of record. I understand I am **not** an employee of the Department of Health and Human Services (DHHS), the South Carolina Department of Disabilities and Special Needs (DDSN), the Jasper County Board of Disabilities and Special Needs or any other state agency.

I certify I am fully ambulatory. I also verify I can read, write, and speak English. I hereby grant permission for the below named Responsible Party to request the following information on my behalf. I understand a criminal records check may be done by the South Carolina State Law Enforcement Division. The results of these criminal records checks may be shared with all potential Responsible Parties. **I understand that I will not be allowed to provide Line Therapy services through the Pervasive Developmental Disorder Program if a criminal records check reveals a conviction for any of the following: a felony, a crime against another person, misuse or abuse of any public assistance program including Medicaid fraud, or abuse, neglect or exploitation of adults/children. I also understand that if I am a provider of Line Therapy services through the Pervasive Developmental Disorder Program and a criminal records check reveals a conviction for any of these offenses, my employment as a Line Therapist will be terminated and all services with any PDD Program consumers will be terminated.** This check will also reveal any confirmed abuse reported. I will not incur any costs as a result of these inquiries. I will provide references to the Responsible Party upon request. I understand I must adhere to basic infection control procedures at all times while providing PDD services. I also realize it is against federal law to delegate my role as a Medicaid Provider to another caregiver.

By my signature below, I understand and acknowledge all of the above requirements.

Line Therapist Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____